

REVIEW OF MEDICARE APPEAL CASES (excludes expedited appeal cases)
WS-AP1

Name/HI Number	Organ. Determ. Date	Date Recon. Request Rec'd	If Favorable Decision, Notice Sent within 30 days* (service)/60 days (claims)?	If extension granted, enrollee informed in writing of reasons for delay and provided grievance rights?	Unfavorable Decision to HCFA contractor within 30 days* (service)/60 days (claims)?	Overturn Decision Effectuated within 30 days* (service)/60 days (claims) if M+CO overturn; 72 hours/14 days (service)/30 days (claims) if independent outside entity overturn; or 60 days (service and claims) if ALJ (or higher level of appeal) overturn?	Comments

Standard: 95 percent correct. Determination: Transfer results to appropriate requirements at AP01-AP12 of the *Review Guide*. *See next page.

Requirement:

*** ALL STANDARD SERVICE RELATED DECISIONS MUST BE MADE AS EXPEDITIOUSLY AS THE ENROLLEE'S HEALTH CONDITION REQUIRES BUT NO LATER THAN 30 CALENDAR DAYS FROM THE DATE THE M+CO RECEIVES THE REQUEST FOR A STANDARD RECONSIDERATION. THE M+CO MAY EXTEND THE TIMEFRAME BY UP TO 14 ADDITIONAL CALENDAR DAYS IF THE ENROLLEE REQUESTS AN EXTENSION OR IF THE M+CO JUSTIFIES A NEED FOR ADDITIONAL INFORMATION AND HOW THE DELAY IS IN THE INTEREST OF THE ENROLLEE.**

! The M+CO must make an organization determination (the M+CO's decision to provide, to authorize, to deny, or to pay for a service) within 14-calendar days of the enrollee's request for the

service or within 60-calendar days of the enrollee's request for payment of a service, (within 30 days for clean claims and within 60 days for all other claims). Failure to provide a notice constitutes an adverse organization determination that the member may appeal.

! The M+CO must properly define and otherwise describe complaints that are organization determinations in the M+CO's evidence of coverage (EOC).

! The M+CO must make the reconsideration service decision within 30-calendar days* of receipt of the reconsideration request and payment decision within 60-calendar days of receipt of the reconsideration request. [If the M+CO's decision is to overturn its initial decision, the M+CO must authorize, or provide-services within 30-calendar days* and make payment for a service within 60-calendar days from the date of M+CO determination.] If the M+CO cannot issue a fully favorable decision, it must automatically forward the case to HCFA's independent reconsideration contractor within 30-calendar days* from the date it receives the enrollee's appeal request for service and within 60-calendar days from the date it receives the enrollee's appeal request for payment. Failure to complete the review within the timeframes constitutes an affirmation of its adverse organization determination and the M+CO must submit the case file to the independent review entity. The M+CO is not allowed to issue an unfavorable decision to an enrollee, but is required to notify enrollee that the case is forwarded to HCFA's contractor. If HCFA's contractor's reconsidered determination is to hold the M+CO liable, the M+CO must authorize the service under dispute within 72 hours from the date it receives notice reversing the determination, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days from that date. For requests for payment if the M+CO's determination is reversed by HCFA's contractor, the M+CO must pay for the service no later than 30 calendar days from the date it receives notice reversing the organization determination. A reopening of a reconsideration determination by the independent review entity does not relieve the M+CO of the obligation to effectuate the reconsideration determination within the required time frames.

Purpose: To determine whether the M+CO complies with regulatory requirements of identifying organization determinations and processing Medicare appeal cases in a timely manner. This relates to Section VIII, Claims Processing, in that the M+CO must pay legitimate unaffiliated provider clean claims within 30 days and process all other claims within the 60-day period so it can notify enrollees of any adverse decision.

Sample/Universe: The universe includes all standard appeals filed on claims and organization determination denials.

In the notification of site visit letter, reviewer will request the M+CO to: Provide a list of all standard reconsideration cases referred to HCFA by the M+CO during the 6-month period ending with the month prior to the scheduled visit (the specific months should be specified in the letter); or that the M+CO made a favorable decision on during the six month period of review upon receipt of the list, approximately 2 weeks prior to the site visit, the reviewer will select 30 cases in accordance with the random selection methods discussed in the *Review Guide* Instructions, under Sampling Methodology. (***Note: During focused reviews, HCFA staff may elect to increase sample sizes to 100 cases or more, as deemed appropriate by the Agency.***) Five (5) to 7 days before the site visit, reviewer will notify the M+CO of the specific units of analysis. The M+CO shall have all necessary documentation for the units of analysis available upon the reviewer's arrival onsite. In addition, the M+CO must provide a separate list of all written complaints submitted by beneficiaries during the same time period that relate to any point-of-service (POS) benefit that the M+CO may offer. These complaints relate to denial of services or denial of claims and upon review, resulted in either a favorable coverage decision by the M+CO or a decision to send the case to HCFA for reconsideration. Upon receipt of the lists, the reviewer will combine this universe with the appeals universe specified above. The reviewer may, at his/her discretion, choose to conduct a focused POS-related appeals review. In this instance, the reviewer will select 30 POS-related appeals cases in accordance with the random selection methods discussed in the Review Guide instructions and proceed to follow the review methodology specified above. In either instance, when selecting the POS review case, the reviewer should annotate those cases that are POS-related.

Column Explanations:

☐ **Name/HI Number:** Self-explanatory. Number optional.

☐ **Organization Determ. Date:** The organization determination date begins the 60-calendar day period during which time the beneficiary may appeal.

M+CO Favorable Decision columns

☐ **Date Recon Request Rec'd:** Regulations specify the time frames for requesting reconsideration; otherwise, the organization determination is final and binding Transfer results to AP08.

☐ **If Favorable Decision, Notice sent within 30-calendar days for service* and within 60-calendar days for payment:** Did the M+CO render the favorable reconsideration decision and notify the enrollee and effectuate the service as quickly as the enrollee's health condition requires, but always within 30 calendar days for standard review and make payment within 60 calendar days of the request? **Transfer results to AP10.**

☐ **if extension invoked, enrollee informed in writing of reasons for delay and provided grievance rights?** If the M+CO extended the timeframe, did it notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file a grievance if he or she disagrees with the M+CO's decision to grant an extension? Transfer results to AP10A

M+CO/HCEA Contractor Unfavorable Decision columns

☐ **Unfavorable Decision to HCEA contractor within 30 calendar days* for standard review and 60 calendar days for payment?** If the M+CO cannot issue a fully favorable reconsideration, it must send the case to HCEA's independent reconsideration contractor as quickly as the enrollee's health condition requires, but always within 30-calendar days* for standard service and within 60-calendar days from the date of the reconsideration request. The M+CO may not exceed this time limit, even for lack of medical records. Was the case appropriately developed and prepared for the independent outside entity? **Transfer results to AP10.**

☐ **Overtaken Decision Effectuated within 30 days* (service)/60 days (claims) if M+CO overturn; 72 hours/14 days (service)/30 days (claims) if independent outside entity overturn; or 60 days (service and claims) if ALJ (or higher level of appeal) overturn: Reversals by the M+CO**

For service requests: Did the M+CO authorize or provide the service as expeditiously as the enrollee's health condition requires, but no later than 30-calendar days (or no later than upon expiration of an extension) from the date of the reconsideration request?

For payment requests: Did the M+CO pay the claim no later than 60-calendar days from the date of receipt of the reconsideration request-

Reversals by the independent outside entity –

For service requests: Did the M+CO authorize the service under dispute within 72 hours from the date it received notice reversing the determination or did the M+CO provide the service as expeditiously as the enrollee's health condition requires but no later than 14 calendar days from the date it received notice?

For payment requests -- Did the M+CO pay for the service under dispute within 30 calendar days from the date it received notice reversing the organization determination?

Reversals other than by the M+CO or the independent outside entity –

Did the M+CO pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health requires, but no later than 60 calendar days from the date it receives notice reversing the determination? **Transfer results to. AP11.**

☐ **Comments:** Self-explanatory. You may want to include comments here (e.g., reason for denial, emergency/urgently needed care) that would help you focus on trends. If POS cases are in the sample, or if the sample is for POS cases, then indicate POS in this column.